Jersey Safeguarding Children Partnership Board
Serious Case Review

Re: The ‘H’ children

Executive Summary

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Serious Case Review Panel chair - Nick Watkins, Deputy Governor, HM Prison
La Moye

1 A pseudonym
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1.0 GLOSSARY

All acronyms and abbreviations are explained in the text and all organisations contributing to the SCR are described fully at paragraph 2.7. However, for ease of reference any abbreviations or acronyms used in the text are also listed below.

ABE Achieving Best Evidence
CIN Child in Need
CIRT Children’s Initial Response Team
CSW Children’s social work
CP Child Protection
ED Emergency Department
EWO Education Welfare Officer
GP General Practitioner
DfE Department for Education
ICPC Initial Child Protection Case conference
MASH Multi-Agency Safeguarding Hub
MoU Memorandum of Understanding
SCPB Safeguarding Children Partnership Board
SCR Serious Case Review
2.0 FOREWORD AND INTRODUCTION BY INDEPENDENT SAFEGUARDING CHILDREN PARTNERSHIP BOARD CHAIR

Independent Chair’s forward and response to the Serious Case Review report in respect of Family H, on behalf of the Jersey Safeguarding Children Partnership Board

2.1 The Safeguarding Children Partnership Board (SCPB) has received and approved the report and accepted the recommendations, which it will ensure are implemented. The report is being published in the interests of transparency, openness and accountability. The honest reflections and contributions of the family and professionals is commendable, it has enriched our learning and is highly appreciated.

What happened to the Family H children is deeply regrettable and cannot be undone, nevertheless, the children are now well, safe and fully supported and we believe that the likelihood of such a situation occurring again is significantly reduced.

The purpose of Serious Case Reviews (SCRs) is to identify and implement learning and we, in conjunction with others, have already addressed several of the recommendations, as well as addressing recommendations from other learning sources, these include:

* Significant additional resources being agreed by the States of Jersey for services to children and families, leading to a doubling of the number of social workers and other improvements.
* The Ministerial Children and Vulnerable Adults Policy group (CAVA) agreeing additional funding for five Family Support Workers who will be in post by this September - the value of this type of support was a key comment made by the mother of the children in this SCR.
* Early Help being established to provide support to children & families at an early stage and avoid difficulties increasing
* Referrals to the Multi-Agency Safeguarding Hub (MASH) showing a steady increase, indicating confidence in the response of all agencies to early indicators of difficulties, safeguarding, including neglect.
* Delivering the ‘1001 days’ initiative: through which additional support will be provided for young children 0 to 2 (the 1,001 Critical Days), 3 to 5 and 6 to 12 years of age. Building the capacity of families and communities and identifying early signs of difficulties, is a golden thread that runs through each of these areas. The initiative will also develop parent/infant psychotherapy services, fund the NSPCC Jersey Baby Steps programme and the implementation of the Baby Friendly Initiative
* The SCPB commissioning training on neglect from Research in Practice, this will be delivered later this year
* HSSD and GPs considering how to change the failure of children to attend appointments from ‘did not attend’ to ‘was not brought’ and how to monitor this
The planned development of the Jersey Practice Model will inform how agencies work together and use shared tools, to ensure ‘joined up’ assessments and plans and avoid children and families having to ‘tell their story’ multiple times.

Glenys Johnston OBE
8th June 2017

2.2 This SCR has identified a number of learning points specific to the issues related to the children who are the subject the review. The learning points have emerged from the consideration of the multi-agency chronology, family contributions and contributions of organisations in Jersey and the learning events and have been distilled into twelve recommendations. The Safeguarding Children Board is very appreciative of the honest and reflective contribution of everyone involved.

2.3 The review has noted where practice has improved since the issues of concern have been identified in this this review and recommendations have not been made where findings have already been addressed.

2.4 The SCPB has accepted all the recommendations as it considers by implementing them through inter-agency co-operation and action, this will significantly move services forward such that children and young people in Jersey will have a better opportunity to be kept safe.

NB. SCRs are about learning, they are not about culpability or blame. They take place with the knowledge that child protection is complex and demanding work and professionals do their best to work effectively- even though their best efforts and doing all the right things does not lead to the desired outcome.
The names of the children and their family have been anonymized, professionals are referred to by the role and some events have been slightly changed in order to protect their identities.

3. A BRIEF SUMMARY OF WHAT HAPPENED

3.1 There are three children in the H family, who for the purposes of this report will be referred to Ha, Hb and Hc. The summary covers three distinct periods of the chronology, relating to the birth of each child up until Ha and Hb were placed in foster care under a voluntary agreement in 2015.

Period 1 2005 to 2008

3.2 Ha was born in 2005 and there was generally no concern about his health or development. However, there was only one ante-natal involvement as the health visitor only became aware of Ha’s mother a month before the birth. It was noted by the maternity unit that Ha’s mother was a single parent with a history of self-harm who
smoked and used cannabis. Although there were indications that Ha was being discharged from hospital into a vulnerable household, no further concerns were noted by the midwife or health visitor.

3.3 When Ha was a few months old, he was taken by his mother to the Hospital Emergency Department (ED). The mother reported that she had fallen with him and he had accidentally injured his head. No other concerns were noted by the hospital, and the mother’s explanation was accepted. A week later Children’s Social Work (CSW) were contacted about the baby being dropped and there being a bump/mark on his head. The mark on this occasion could have related to the injury reported at the earlier A&E attendance, but, could have been a new incident. Although telephone enquiries were made to the health visitor and GP by CSW, no initial social work visit or assessment was made. At that time CSW did not routinely complete initial assessments about safeguarding concerns, which were at the duty team manager’s discretion. The parents were contacted and offered two appointments to discuss the concerns and offer support, but as no response was forthcoming CSW closed the case two months later. Following a further expression of concern, CSW re-opened the case offering the father a further appointment, which he did not attend.

3.4 The baby had his nine-month developmental assessment where nothing abnormal was noted. However, this assessment was delayed as his mother did not take him to the appointment. Failure to attend or take children to medical appointments occurred many times afterward. Shortly after this the parents ended their relationship following a domestic violence incident which Ha may have witnessed. An initial social work assessment was reported to be completed though there was no record of this and the case was closed again, although the social worker contacted the health visitor to say the mother was in need of support.

3.5 When he was a year old his mother began a new relationship with a partner who had substance abuse and mental health problems and was being abusive toward her. When Ha was two years old his mother failed to take him for his developmental assessment and he was not seen for a further three months, despite regular reminder requests by the health visitor. There was no evidence of further attempts to give mother support following the social worker’s request at the end of 2005. The mother did not respond to the health visitor’s requests to contact her, which should have raised concerns of non-engagement, but the health visitor had not had concerns with the care of Ha by his mother, and universal health visiting continued.

3.6 In early 2007, an ambulance was called as a member of the household had made a suicide attempt. The ambulance crew made a referral to CSW as they were concerned that Ha had witnessed this. A social work assessment was expected to be completed though again there was no record of this and CSW’s involvement was closed. Nine months later the Police made a referral to CSW as Ha’s mother was arrested for stealing nappies and food from shops on two occasions. The Police report stated she was suffering financial hardship and that benefits which should been used to care for Ha
were being used for other purposes. At this point it was revealed that the mother was pregnant and a pre-birth assessment was recommended. HA’s mother admitted that she was using heroin intravenously and was referred to the Alcohol and Drug service though she did not engage with them and refused a methadone programme on the grounds that it might harm the baby. The Alcohol and Drug service later closed their involvement. There was no evidence that the impact of the parents’ substance use on Ha was considered and proper protective actions taken, for example Ha should have been immunised against Hepatitis B. Ha was not seen by a health visitor or social worker for nearly five months from July 2007.

3.7 Early in 2008 a maternity planning meeting involving a CSW duty social worker was held and among the concerns noted were the following:

- the father of the unborn child’s aggressive behaviour and the safety of Ha’s mother;
- father’s substance use whilst caring for children as mother neared the end of her pregnancy;
- both parents’ drug use in the household with risks to children seeing parents injecting and injury /infections from heroin syringes;
- unreliable drug using friends in the family home;
- concerns over parenting and that there would at times be up to four young children living in inappropriate accommodation;
- mother’s lack of attendance at all preceding antenatal appointments and the health needs of the unborn child, i.e. small for dates and being born drug dependent; and
- parents putting their needs first, neglecting Ha and the father’s hostility toward the health visitor, to the extent that she formally stopped visiting due to the risk from him.

A major outcome of this meeting was that CSW would become re-involved to complete a pre-birth assessment with the possibility of Child Protection Conference and Proceedings. Three weeks after this meeting, the father of the unborn child was arrested and remanded into custody for drug offences.

**Period 2 2008 to 2010**

3.8 In early 2008, Hb was born and was placed in the Special Care Baby Unit, due to prematurity and to monitor his drug withdrawal. Hb’s mother was seen in hospital by a social worker and then a home visit was made. The social worker found that Ha was sleeping in a cot that was too small for him with no mattress and that unsuitable people were caring for him in his mother’s absence. In light of this, Ha’s mother discharged herself against advice to look after him due to the concerns expressed about inappropriate carers and made arrangements to visit Hb on the ward. At this stage, she was still using substances intravenously. (When this SCR report was shared with the children’s mother, she stated that she was not using substances at all at this point.)
3.9 Shortly after Hb’s birth an Initial Child Protection Conference (ICPC) was held. Despite considerable concerns at the time the decision was made not to register Ha and Hb but to manage the risks through the child in need (CIN) planning process. Several recommendations were made including: a core assessment, monthly ‘core group’ meetings, renewed Alcohol and Drug services’ involvement, for mother to consider a parenting course and a Review Child Protection Conference (RCPC) to be held if Hb’s father returned home.

3.10 Following Hb’s discharge from hospital, home help and support was offered by; the health visitor, a nursery nurse and, drug and alcohol workers and a new social worker visited regularly to complete a core assessment. Although some improvements in parenting were noted over the next three months, the children’s mother relapsed into drug use and did not attend the majority of appointments with Alcohol and Drug Services. (When this SCR report was shared with the children’s mother, she stated that she had not relapsed into using ‘drugs’ and therefore saw no reason to attend Alcohol and Drug Services.) She continued to leave the children in the care of inappropriate adults and received continued telephone threats from Hb’s father and associated people trying to collect drug debts. A final CIN review meeting was held and it was decided that the case would be closed to CSW, with recommendations for ongoing work, supported by a Shelter Trust worker, health visitor and the alcohol and drug service, and that a day nursery placement should be provided for Ha due to his lack of contact with other children. At this time CSW was undergoing severe staffing and work related pressures and all non-statutory casework was closed shortly afterward.

3.11 At the end of 2008 Hb was taken to hospital with burns caused by scalding and an accidental explanation for the injuries was accepted. By that time the mother had separated from Hb’s father and had started a new relationship and begun living with her new partner who though not a heroin user, smoked cannabis.

3.12 Ha started school in 2009 and his first school report at the end of that year noted he was happy and energetic although he needed additional help to become more independent.

Period 3 2010 to 2015

3.13 In early 2010 Hc was born to mother and her new partner. Hc’s mother did not notify her GP or health staff of this pregnancy and no ante-natal monitoring or care was provided. It became apparent from birth onward that Hc had very significant physical development and then learning needs.

3.14 Shortly after the birth of Hc, Ha began to become incontinent at home and the middle of 2010 his behaviour had become challenging, particularly toward his new stepfather. Ha’s mother could give no reason for this to her health visitor who was
concerned that he was showing a high level of stress and unhappiness. By the summer of 2011 Ha was assessed by his school to have learning difficulties and was placed on an Individual Learning Plan.

3.15 By early 2012, Hc’s father was made redundant which added considerably to the stresses within the family, particularly as the mother had to work at two jobs to ensure a family income. Hc’s father thus became the main carer for the three young children all of whom had additional and complex needs. By the autumn term of 2012 Hb started at primary school and because of learning difficulties was referred for speech and language therapy. At the end of 2012 when he was nearly seven years old, Ha had become very unsettled at school and his mother reported finding him difficult to control at home. By early 2013 Hc was also assessed as having very significant learning difficulties and presented substantial management challenges due to hyperactivity, head-banging, tantrums and sleep problems.

3.16 In early 2013 a markedly deteriorating situation emerged at school for Ha and Hb. Concern was expressed that Ha had no reading glasses and this was having a detrimental impact on his learning. Despite this there was no follow up or prompt resolution of this problem by professionals at the time. Ha had been asking other children to share their lunch with him which they have been doing and had also told staff he was hungry and was getting no breakfast. Similarly, Hb was taking food from other pupils’ lunch boxes. In May 2013 Ha made a disclosure that his stepfather had handled him roughly while he was sleeping, that he had fallen on the floor and been physically hurt. Ha also disclosed that his stepfather force-fed him and made him sick. The school contacted CSW for advice and were told that it would not be treated as a referral but that they should discuss the disclosure with his parents directly. The school spoke with Ha’s mother who acknowledged a relationship problem between Ha and her partner and some advice was given. In June 2013 Ha made a similar disclosure that his stepfather had physically hurt him and that he was made to stand for long periods with his face to the wall. On this occasion the school made a referral to CSW who made a home visit. Both parents denied the allegations but mother gave consent for Ha and Hb to be interviewed at school and Ha maintained his disclosures, although Hb was not interviewed. At this stage, Ha, should have had a CP medical where his growth would have been looked at as part of the assessment which would have revealed his very pronounced drop in centile growth and would have supported his disclosure that he was not being properly fed. CSW closed the case after a month, supposedly after completing a single agency assessment and talking with the parents about managing the behaviour of Ha. There was no record of this assessment.

3.17 In early 2014 a number of incidents of concern regarding Ha occurred, including being hurt by his stepfather and shouted at, as well as going without breakfast. The school attempted to deal with these incidents by meeting with the parents in March and offering them support to manage the situation and later a referral was made to the school nurse to advise over Ha’s appetite and portion sizes. In August Ha was taken to
the hospital ED with a facial laceration, the non-accidental explanation of the injury by the parent was accepted. Over the next month, the school noted that Ha was again presenting as being hungry at the beginning of the school day and was witnessed as being upset and crying when his stepfather brought him to school. Hc who was nearly four years old at this point, was exhibiting substantial head banging and challenging behaviour at home, but not at school.

3.18 In November 2014 a member of school staff witnessed that the stepfather was visibly angry with Ha as he was taking Ha to school ‘pulling him by the wrist with a clenched hand’ as Ha was resisting him. Ha complained of being bullied by his stepfather and the school referred their concern to the Multi Agency Safeguarding Hub (MASH) and CSW and the Police undertook a joint child protection investigation. The investigation included a medical examination by a forensic medical examiner rather than a paediatrician and Ha was found to have small bruises on his upper arm though he did not disclose to the doctor how he sustained them and the appearance and cause of the bruising was inconclusive. Ha did not make a formal complaint against his stepfather but did wish the Police to speak to him. There was insufficient evidence to proceed and no further action was taken by the Police. CSW produced a brief initial assessment which recommended the need for parenting support through the Bridge Centre. The parents expressed agreement for this plan but only one session was attended and subsequently the service was withdrawn through lack of engagement by the stepfather.

3.19 In March 2015 a referral to the MASH was made. The referral detailed various serious concerns about abuse of the children. After consideration of the referral and the history of the case, MASH closed the case and advised the parents to again seek parenting advice from the Bridge Centre, without interviewing the children or conducting a further assessment. At around this time an educational psychology report was completed on Ha and noted that his significant learning difficulties were being compounded by low self-confidence. During June and July, concerns were also raised about Ha missing several dental appointments.

3.20 At the beginning of August 2015, during the school holidays a further referral was made to the MASH with increased concerns that the children were being abused. A referral was made to the CSW Children’s Initial Response Team (CIRT) for an initial assessment and risk rated medium or ‘Amber’. The rating had not been challenged by members of the MASH core team and was considered appropriate by the MASH decision maker and CIRT manager.

3.21 The case was allocated to a social worker in CIRT one month later. Workload pressures in CIRT were reported to be considerable at the time and only high risk ‘Red rated’ cases were being prioritized for immediate assessment. The referral remained ‘Amber rated’ and was among 25 cases that were unallocated during the period of the delay. A further delay of nearly four weeks occurred until Ha and Hb were visited by a social worker to gather information for an initial assessment, though no preceding child
protection strategy meeting had occurred. Both children disclosed ongoing physical and emotional abuse. The social worker requested Police attendance and a joint child protection investigation began. Both Ha and Hb re-confirmed their earlier statements of physical assault. Hb reported to the social worker that he was being regularly strangled and yet no CP medical was requested, apart from missing important evidence he could have had suffered serious physical harm. The boys’ mother did not accept the risks posed to the children from her partner and Ha and Hb were placed in foster care under a voluntary agreement.

3.22 Subsequent ‘Looked After Children’ medicals on both children discovered that Hb’s height and weight were very considerably below average and that he had symptoms commonly found in children with extreme malnourishment, hair growth on his body as well as bruising to his neck, consistent with strangulation. Ha was also found to be very considerably below the height and weight average for his age, had symptoms of poor dental care and his reading glasses were broken and had not been replaced. Since being in care both children’s height and growth rate has very significantly accelerated and they are now progressing close towards the centile positions they should have previously reached.

4. THE VIEWS OF THE PARENTS

4.1 The mother of the children and her partner [father of Hc] (but no other family members) agreed to be interviewed as part of the SCR to give their account of what happened, the involvement of services and what could have helped to avoid the removal of Ha and Hb. The comments are those of the parents and as far as possible use their words and reflect their experiences and opinions. They are not necessarily endorsed by the author.

- more help from their extended families;
- earlier assessment and understanding of Ha’s needs and behaviour, which impacted on home and school would have helped;
- if help with parenting had been available to them when they asked for it, they wouldn’t be where they are now;
- the support they needed was in the family home from one person with practical strategies, someone to work with all the family, and, if additional parenting courses were required then it would have been clearer what the purpose of the courses would be; and
- help from the Child Development Team worker in the home has made a big difference with Hc as the worker understands Hc much better and mother feels that she was not given the choice to be a “superhero” mum with Ha and Hb.
5. ANALYSIS: INTRODUCTION

5.1 This section of the review aims to consider why “what happened, happened” and how organisations can learn how to prevent the emotional abuse and neglect experienced by the ‘H children’, happening to other children and young people in Jersey.

5.2 The following analysis seeks to be proportionate, drawing from the chronology, the contributions of agencies and family members and the most important areas of learning, so that all relevant services can be improved.

5.3 Where practices have changed since events documented within the review period, this is noted and taken into account where recommendations for improvement are made.

5.4 There are five areas of analysis in this case which examine the following:

- the identification of neglect and emotional abuse
- the voice of the child
- risk assessment and building a clear historical picture
- early help its use and role
- information sharing and professional challenge

6. ANALYSIS: THE IDENTIFICATION OF NEGLECT AND EMOTIONAL ABUSE

6.1 Neglect is the most common form of child maltreatment. For example, Brandon et al 2014¹ notes, “During 2013 in England almost half of child protection plans occurred as a response to it and it also featured in 60% of serious case reviews. However, a number of high profile child deaths in the UK have shown that it is extremely difficult for professionals with safeguarding responsibilities to identify indicators of neglect, to assess whether what they have seen is serious enough to take action and to decide on the most appropriate course of action.”

6.2 Working Together 2015² defines neglect as: The persistent failure to meet a child’s physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care givers); or
- ensure access to appropriate medical care or treatment.
6.3 Further to this, the glossary to Working Together 2015 defines emotional abuse as:

- The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.
- It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate.
- It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.
- It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.
- Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

6.4 Many opportunities to identify and act on indicators of neglect and emotional abuse of the children throughout periods 1, 2 and 3 of the chronology were missed, for example;

**During period 1:**
- mother’s late engagement with ante natal services;
- the parents’ lack of engagement with agencies and their superficial compliance, leading to CSW ‘s closure of case involvement without a thorough risk assessment;
- Ha’s not being taken to the 9 and 24 month developmental checks/ delayed vaccinations and the family needing to be persistently chased to comply;
- Concerns that mother that family income was not being spent on food and care of the children, though this did not trigger concern that Ha would experience neglect; and
- the emotionally abusive impact on Ha of mother’s new partner considered to be too threatening for the health visitor to visit the home.

6.5 **During period 2:**
- Ha sleeping in a cot that was too small with no mattress;
- unsuitable people in the home caring for the children in mother’s absence drifting on without resolution despite persistent warnings;
- mother’s superficial compliance with a child in need plan; and
• mother’s non-engagement with the Alcohol and Drug Service.

6.6 During period 3:
• all three siblings reported as ‘hungry’ in school from 2013 onward, though this was not responded to as symptomatic of emotional abuse/neglect and the parents’ explanations that the children were well fed but just had exceptional appetites was tacitly accepted;
• the pattern of parents finding it progressively more difficult to control the children develops and all three children being assessed at different stages as having significant learning difficulties;
• disclosures of physical and emotional abuse in school twice in 2013 (only one reported to CSW) and once in 2014 to school with no further CSW involvement or action after inadequate social work assessments of need;
• parents’ non-engagement with a parenting advice programme, between November 2014 and July 2015;
• the first child protection referral in March 2015 about abuse of Ha and Hb was not acted upon as it was thought the family were notionally involved in a parenting advice programme and the MASH’s suspicion that the referral could be malicious;
• Ha’s regular failure to attend dental checkups; and
• the final child protection referral about Ha and Hb to MASH in August 2015.

6.7 Historic responses to the mother’s vulnerability, observations that she had a positive relationship with the children despite her superficial engagement and compliance with agencies involvement in all probability contributed to what Munro, (2002) describes as, ‘a fixed view of the family’, i.e. one that is arrived at an early stage and not challenged or changed as further concerns emerge.

6.8 In some instances, the indicators were more severe and alerted the involvement of CSW most notably in 2008. However, the fact that these concerns did not result in child protection registration in 2008, and that the risks were seen as appropriately manageable at a lower level thereafter without CSW’s ongoing involvement, was the point from which a “fixed view “developed about the family over time, without revision, based on a mistaken assessment of both the risk indicators and protective factors.

6.9 From 2013 onward, by default, schools had the main oversight of the children and their links with their parents. Schools clearly tried hard to work with the parents and as a series of more severe and worrying indicators of neglect and emotional abuse emerged, shared some of these with CSW. However, the parents’ interpretation of Ha’s and to a lesser extent Hb’s challenging behaviour at home and their request for additional support around boundary setting was in effect taken as an acceptable level of engagement. Whether this was based on the teaching staffs’ view that although the children’s behaviour was worrying and aspects of their parenting were of concern but
not deliberate or intentionally abusive, is not clear. Following the referral to CSW by the school in late 2014, the inconclusive finding of the joint child protection investigation, inappropriate closure of CSW involvement and the recommendation for parenting advice again appears to have fixed the professional view of the family. This fixed view persisted despite later evidence that the offer of parenting advice was not being accepted or used. Farmer and Lutman 2014 note that, “Neglect is often identified but not notified by agencies including social services until a significant trigger event occurs, usually an incident of physical or sexual abuse, and only then is decisive action taken.”

6.10 The first referral of concern about the children in early 2015 was examined by the MASH but again the indicators of emotional abuse were not seen as sufficient to revise the assessment that had been made of the family situation in late 2014. It was not until August 2015 when a similar referral was made that the MASH decision taken was to reassess the situation although some scepticism about the reliability of the referral led to its lowered priority for assessment.

Learning events comments:

6.11 The practitioner and managers’ learning events confirmed that there has been a lack of in depth training around neglect and emotional abuse and that multi-agency training in this area should be a key learning and development priority. Similarly, it was felt that there should be access as a priority to multi-agency training on ‘Working Together’ 2015 to reinforce understanding of roles and responsibilities.

6.12 Although in the past there were significant contextual reasons, notably severe resource issues, which explained in part the failure to the identify risk indicators with these children, several participants who have worked on the island over a long period noted that they knew of a number of ongoing ‘legacy’ cases which had very similar unsettling characteristics of neglect to this one. Many participants noted that the status of child in need work has had, and continues to have lower priority within CSW, as it is the area of work under most pressure to resolve quickly, close down, or transfer appropriately or otherwise to early help providers against the competing work priorities of child protection and ‘looked after children’. Some CSW practitioners felt that there were significant obstacles to properly resourcing ongoing child in need social work support and monitoring over the long term, with children in some families where their care would only ever be just good enough.

6.13 Some participants also mentioned the historical context prior to the development of the MASH, where there was a lack of professional confidence in CSW by other agencies, the court and families due to the inconsistency of approach and judgment by CSW managers and social workers, which led to a reluctance to refer in cases such as this. It was noted after the learning event that a recent meeting had occurred between CSW and the Courts to inform the Court of recent developments within CSW.
7. ANALYSIS: THE VOICE OF THE CHILD

7.1 Throughout the chronology there are examples where some of the children felt sufficiently confident in school staff to make disclosures which raised concerns about how they were being parented. The schools certainly showed concern about these disclosures and shared them with the mother, stepfather and CSW. However, there was no evidence in the chronology to suggest that the concerns of school staff were at any stage recognised as symptomatic of emotional abuse/neglect.

7.2 Up to the end of period 2, assessments completed by CSW did not feature the voice, views or experiences of the children to any appreciable extent. The core assessment completed in June 2008 was the most comprehensive of all the assessments completed by CSW. At that stage, Ha was three years of age with limited verbal ability and the social worker was led by mother’s interpretation of his behaviour, as well as observation of their positive interaction. Following a referral from Ha’s school in 2013, when he disclosed being physically injured and emotionally abused by his stepfather, CSW interviewed Ha at school after discussion with the parents and decided the issues were primarily about deficient behavioral management rather than anything more significant. On this occasion, it appears that Ha’s voice and account was not accepted and that the parents’ interpretation was seen as fair and they were given advice about how to manage him, without any written assessment or validation for this approach. After this there was one recorded CSW assessment in November 2014. This initial assessment was part of a child protection investigation and was very superficial. The children were seen on one occasion and Ha was interviewed in the family home by CSW and the Police. Ha maintained that he had been physically hurt by his stepfather but was not prepared to make a formal complaint though he requested that the stepfather be spoken to about physical abuse and bullying of him. The assessment failed to record that Ha had significant learning difficulties and that on a number of occasions during 2013 and 2014 Ha and Hb told school staff that they were hungry had not been given breakfast, and that Ha reported being physically abused and bullied by his stepfather on a number of preceding occasions. The assessment did not cover or explain this and either school staff did not report these antecedent concerns at the time of the assessment, or they were reported but not mentioned by the social worker in the report. The fact that Ha requested for his stepfather to be spoken to but was not prepared to attend an ABE interview or to make a formal complaint appeared to be seen as undermining the reliability and truthfulness of his disclosure. There was apparently no consideration that he might be very scared of his stepfather and of the potential repercussions for him within his family. The outcome of this event was to repeat earlier recommendations for parenting advice to enable the parents to cope with Ha’s behaviour and CSW closed their involvement quickly afterward. Ha and his stepfather attended one session of parenting work in January 2015 but the stepfather chose not to engage with any further work. The opportunity for Ha to potentially voice his feelings and concerns in these parenting sessions was cut off again.
7.3 A further opportunity to hear the voices of Ha and Hb was lost following the child protection referral made to the MASH in March 2015. The referrer was very concerned for the safety of the children. The MASH was sceptical about the referral seeing it as being possibly malicious and without further investigation or assessment, the parents were advised to go for parenting advice even though they had then disengaged with the service providing this.

7.4 The report by Ofsted\(^\text{6}\) (2011) on the themes and lessons to be learned from Serious Case Reviews between 1 April and 30 September 2010, highlights five main messages with respect to the participation of children:

- *the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings*
- *practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child*
- *parents and carers prevented professionals from seeing and listening to the child*
- *agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute*
- *agencies did not interpret their findings well enough to protect the child*

**Learning events comments:**

7.5 The practitioner and manager learning events identified that it is still the case in current practice that the voice of the child can be lost sight of. Despite strong messages from the top of partner organisations that a child-centred system is a key objective, a number of participants felt under great pressure to meet the basic requirements around assessing children’s needs, wishes and feelings within the required tight timescales. Having insufficient time to develop relationships of trust in order to complete complex direct work with children was also cited as a concern, particularly with children with special needs, as well as the required level of skill and training to undertake this work.

8. **ANALYSIS: RISK ASSESSMENT AND BUILDING A CLEAR HISTORICAL PICTURE**

8.1 The chronology shows a persistent pattern of under-assessed risk across all three time periods. At the outset in Period 1, following the birth of the first child, there was a lack of professional curiosity and early attention to mother’s self-reported vulnerability, i.e. being a single parent with mental health issues and drug misuse. The potential risk indicators for the health of the child were not considered sufficient to refer to CSW. Similarly, a lack of rigour by CSW in assessing the child’s presentation at the ED and the subsequent child protection referral led to reasonable concerns about the neglect being deflected by the non-engagement of the mother and her then partner in 2005, with no risk assessment.
8.2 Just prior to Hb’s birth, the level of concerns had reached a high point and an ICPC was called in early 2008. The ICPC was not effective. It lacked focus on the risk indicators and needs of the children because of an overly positive view of the mother’s ability to protect the children. Similarly, the conference did not have a historical view of mother’s background, parenting ability and significant antecedent events. Because of this an under evidenced analysis missed the opportunity to properly address significant safeguarding issues. Despite substantial opposition from the majority of conference members, the decision was made not to register Ha and Hb. The chairperson’s judgment appeared to be based on the hypothesis that the most significant and immediate threat of harm was from Hb’s father and that the parents’ history of addiction, chaotic parenting and lack of effective engagement with agencies, could be successfully addressed voluntarily through a child in need (CIN) plan and a parallel core assessment.

8.3 Following the ICPC and as the CIN meetings progressed, only minor improvements were noted. The core assessment provided a chronology and partially uncovered the mother’s troubled childhood but did not provide a clear analysis or judgment of how her own childhood experiences impacted on her ability and commitment to parent Ha and HB alone, or the weakness and unreliability of her own support network. Following the final CIN meeting in June 2008, without a clear parenting assessment, the case was closed to CSW three months later because of resource pressures and not reopened until 2013 at the onset of new child protection concerns.

8.4 As has been documented in Section 6 and 7, the CSW assessments produced as part of child protection referrals is 2013 and 2014, lacked substance and thorough analysis. The assessment completed in 2013 was not recorded or signed off by a manager and there is no evidence that preceding concerns were taken into account in supervision or that proper multi-agency research took place. The 2014 CSW assessment was, as mentioned before very superficial and reactive and it was not until the second referral in 2015 that finally disclosures from the children triggered appropriate action.

8.5 Emotional abuse and neglect is generally a slow, cumulative process, requiring a considered multi-agency assessment of the pattern and sequence of events rather than a narrow unreflective reaction to single incidents. The chronology constructed for this SCR contains a significant amount of accumulated information held by schools and health staff between 2008 and 2015, which pieced together shows the developing picture of isolated parents struggling with three children who had appreciable and complex special needs. One of the showed clear signs of becoming more neglected and emotionally abused as the parents sought to control their children’s behaviour, without this being explicitly recognised in individual agency records. Regrettably, this information was not sought by or shared with CSW for assessment purposes. As Farmer and Lutman 2014 point out, “Often, the situations which constituted neglect were not referred to as neglect on the files and no cumulative picture of the extent of neglect and its consequences was built up, even though some children were noted as being developmentally delayed or years behind with their schoolwork.”
8.6 It was evident that record keeping was often incomplete, communication of important incidents or concerns was inconsistent and that a sound practice framework using chronologies for supervision and planning was not in place. Where neglect and emotional abuse is clearly identified by partner agencies through shared information, the use of chronologies, then careful core or parenting assessments, makes frank and clear communication with parents about their neglectful and emotionally abusive care easier. With some families, focused collaborative family work can have positive impact through in depth parenting assessments, direct work with their children, clear goal setting and written agreements. Where parents show persistent ambivalence to engagement with helping agencies and making progress with the agreed work plan, then the basis for more coercive legal action is made possible.

8.7 As Brandon 2008⁷ points out: “Professionals need to consider the debilitating impact that neglectful families have on the way workers think, feel and behave. It is important to have clear mechanisms to report and discuss concerns and to build up a systematic picture of risks and protective factors. Where neglect is endemic, long term plans are needed to support children and parents over an extended period. Practitioners and managers must also be able to gauge when care from parents and networks is not adequate (good enough) to meet children’s developmental needs or ensure their safety, and to consider that children might need to be removed from home.”

Learning events comments:

8.8 Participants at the learning events noted that, although it is work in progress, there has been recent improvement in CSW’s assessment and recording practice, especially maintaining chronologies on new files and the regular completion and signing off of assessments by managers. However, many older CSW ‘legacy’ files exist which have missing chronologies and other important information which make it difficult for newly allocated social workers to properly understand in depth information about children and their families, especially given caseload pressures. Similarly, some CSW participants noted that the continuous movement of many agency social workers at short notice often leads to incomplete record keeping and proper case transfer arrangements and the building of relationships with families and professionals.

8.9 The completion of core assessments is time consuming and engaging other agencies to make contributions can be difficult. It was suggested that because of often competing priorities and professional language barriers that interagency agreements should be reached about jointly contributing to assessments.

9. ANALYSIS: EARLY HELP ITS USE AND ROLE

9.1 In 2008, when CSW completed a core assessment, there was a clear and appropriate recommendation for one of the children to attend a day nursery due to their isolation
and lack of opportunities to play and socialise with other children. Mother engaged with this for a short period and some peripatetic nursing involvement was provided after the birth of the second child, although no day nursery or NNEB assessment was visible.

9.2 In early 2014, it became clear to the school that the parents were having behavioural problems with the children that the dynamics within the family had become very tense. The initial response by the school was to seek help by getting the parents to have some sessions from the well-being support team. Although Ha’s mother showed some initial interest in this support it was not taken up till later in 2014. The well-being support team noted that Ha was referred because of the assessment that he was ‘emotionally vulnerable in school, struggled with relationships in his family and was making very slow progress’. The team recorded focusing their efforts on getting Ha to control his anger and reported some success. The focus of the team appears to have been on Ha’s behaviour not the whole family or the parents’ methods of discipline.

9.3 Following the child protection investigation in 2014, Ha and his stepfather were recommended to voluntarily attend Parenting Services to work further on their relationship. This recommendation depended on Ha’s parents being motivated and collaborative rather than just superficially compliant. Ha and his stepfather attended one session of the “In–Betweeneries” course in January 2015, after which the stepfather subsequently did not attend. Several attempts were made by the school and the Bridge Centre to encourage continued involvement prior to withdrawal of the service in July 2015 because of non-engagement. In March 2015, the mother reported to the school that the situation at home was much worse as two of the children were ‘picking’ on their sibling. The first child protection referral to the MASH in March resulted in no further action or CSW assessment and parents were again advised to go for parenting advice, despite their previous non-engagement.

9.4 Brandon et al 2012, in a review of the cases of children subject to serious case reviews during the period 2009–2011, noted that, “thresholds to children’s social care were generally set too high, particularly where neglect was the primary concern.” Without significant involvement of CSW and other agencies and without a current and in depth assessment of the parents’ abilities and the lived experience of the children at home, school was left to organise what they felt to be appropriate support. As CSW had judged the situation as being below the threshold for their involvement the school took the course of attempting to get the family to reconsider using the Bridge Centre support although the scale of the issues within the family were now well beyond that of voluntary participation in a parenting course.

9.5 Brandon et al 2008 in an analysis of Serious Case reviews between 2003 and 2005 make the following key observations about working with cases of neglect:

- “The risks of recurring maltreatment are higher with neglect than other types of abuse. Practitioners need support to prevent them becoming overwhelmed and to help them to think and act systematically in cases of neglect and to avoid the
‘start again’ syndrome.” (*A syndrome where workers deal with often confused, contradictory and overwhelming historical information by putting it aside to focus on the present.)

- “… behavioural approaches focusing on the present and family strengths (for example parenting programmes) were being used as part of the ‘start again syndrome’. The principle of concentrating on strengths, and breaking down desired parental change into small achievable targets is appealing and appears to offer stigmatised families a chance to prove their ability as parents. However, although apparently successful for families with low level needs, this approach can have serious drawbacks when used with families with deeper more entrenched problems, not least the dangers of setting aside family history in the focus on the present and not taking into account a lack of progress. There is a growing evidence base indicating that short term, behavioural approaches are not likely to succeed with families with long standing, complex problems.”

Learning events comments:

9.6 Participants at the learning events noted that the newly developing approach to Early Help is welcome. However, as this case demonstrates it was accepted that without accurate assessments, particularly parenting assessments, similar instances of inappropriate referral to centre based parenting programmes can occur. More generally where early help resources such as parenting advice courses are clearly not engaged with, this is not always being communicated effectively between agencies involved with the children. The view was also expressed that there should be a proper review of the need for a home-based parenting support resource, such as family support workers.

10. ANALYSIS: INFORMATION SHARING AND PROFESSIONAL CHALLENGE

10.1 There are numerous examples throughout the SCR chronology where information was either assumed to be known or was not formally shared or confirmed, or, where inter-professional challenge of decision making should have occurred. Among the most significant of these were:

Period 1

10.2 In 2005 the midwifery service and then the health visiting service showed a lack of professional curiosity and early attention to mother’s self-reported vulnerability i.e. single parent, mental health issues (self-harm) and drug misuse. At that time, no referral was made to CSW.

10.3 In early 2007, CSW became involved in assessing child protection concerns, mother entered a volatile and abusive relationship and she and her partner were using substances however, at the time none of this information was shared with the health visitor.
10.4 By early 2008, the situation had become considerably worse and it was not until then at a pre-birth meeting when the concerns were aired two months before the birth that the health visitor was alerted to the situation. Had the information been shared a year earlier then it is likely that the health visiting service would have been more intensively involved.

**Period 2**

10.5 By the time of the ICPC in 2008, most of the originating child protection concerns persisted and despite the majority of conference participants wishing to place the children on the Child Protection Register, the conference chair supported the case being treated as a CIN case only. At that time, there was no professional challenge to the chair’s decision. This was in part due to the lack of a formal pathway to escalate and resolve concerns about the chairperson’s decision making, though the lack of a protocol, later introduced by the SCPB in 2014, did not prevent challenge or informal escalation.

10.6 There were three recorded CIN meetings where it was evident that the goals set for the mother were not being met and only minor improvements were being made. At the final CIN meeting, CSW’s core assessment was shared along with the recommendation for the case to be closed to CSW but that there would be ongoing input from the other agencies. No professional challenge was recorded regarding this plan despite an incomplete core assessment and most of the original concerns remaining unresolved.

**Period 3**

10.7 From the point of the last CIN meeting in 2008 and CSW’s withdrawal shortly afterward until early 2013, the agencies operated separately with no recorded communication.

10.8 From March 2013 until June 2015, there were six incidents where two of the children were reported as being hungry at school or taking food from other pupils, none of these incidents were reported to CSW. Between May 2013 and November 2014, on seven occasions, one of the child made disclosures of emotional and/or physical abuse by his stepfather. On the first occasion the school was told by CSW to deal with the parents directly without making a formal referral to them. On the second occasion the school spoke directly by phone to the parents with no further action. On the third occasion CSW accepted the concerns of the school and completed an initial assessment, shortly afterward closing their involvement and handing the lead role back to the school. On the fourth, fifth and sixth occasions the school did not refer to CSW, possibly because of the previous response and advice to deal with the incidents as behavioural matters directly with the parents. On the seventh occasion a referral was made to CSW, which after a child protection investigation resulted in CSW handing back the lead role to the school and withdrawing. It is not clear why the school did not seek to formally
challenge CSW’s response when there was a clear and growing pattern of the emotionally and physically damaging impact on Ha by his stepfather. However, it is evident that consultations from the school with CSW then the MASH, did take place and that the advice for the school to deal with the matters directly with the parents was given, though these consultations were not recorded by CSW and only partially by the school. It is likely therefore that the judgment of the school was to continue to deal singly with presenting concerns in this way, until another significant trigger concern occurred.

10.9 There is no record of communication between the children’s schools throughout this period, even though the mother disclosed a great deal to staff in both schools about difficult dynamics between all the children at home. At no stage did either school seek to gain the consent of the mother to share information across the schools even though there would have been significant potential safeguarding benefits from doing so.

10.10 There was no evidence of a written or face to face handover to the school nurse by the fifth health visitor. No further information was visible in Hc’s records until 2014 leaving a gap of two years without involvement in the children’s care. This would have met the standards of the Healthy Child Programme for two of the children, given that they were assessed as requiring routine health visiting and school nursing. However, this should have been challenged, as during this period the situation within the family had significantly deteriorated for Ha and Hb and in addition, there were substantial stresses for the parents in regard of Hc.

10.11 There are numerous examples where dental and orthoptist checkups for all the children were missed and although recorded and sent to the GP this information was not communicated directly to, or picked up, by the health visitor or school nurse.

10.12. It was significant that the MASH chose not to share with Ha and Hb’s school the content of the child protection referral in March 2015, deciding to discuss this only with the parents assuming that other parenting work would be ongoing. To compound this, the mother spoke with the school four days later, disclosing that the situation had got worse at home as Ha and that she and her partner had received threats to kill, the school similarly chose not to share this concerning information with CSW or the health visitor.

10.13 The final child protection referral to the MASH in August 2015, initially resulted in a risk rating of “Amber” for multi-agency information gathering. The research took four days and was incomplete as it was lacking a risk chronology which took into account significant recent events, particularly from the school. On this basis and without full direct discussion with researchers, the MASH team manager made the final decision to grade the risk as “Amber” for an initial assessment to be conducted by the CIRT. The Education researcher was concerned about the referral and understood that it would go straight to an initial joint child protection investigation that day. This incident illustrates
some systemic difficulties within the MASH in ensuring good communication and appropriate challenge within the MASH particularly where researchers are not available within the MASH team room. By this stage there was a long history of known concerns and enough risk indicators to have convened a child protection strategy discussion.

10.14 When after allocation of the case to a social worker in CIRT occurred and the initial assessment took place eight weeks later, two of the children disclosed incidents of physical and emotional abuse by their stepfather at which point the social worker asked for Police involvement in the interview with the children and parents which resulted in the children being moved to foster care that day. A strategy meeting was convened the following day, however, neither the designated nurse or paediatrician were invited. Consequently, the opportunity to immediately complete a full child protection medical was missed. The child protection medical would importantly have enabled the children to be examined and interviewed without their mother being present. During the subsequent medical examination, two weeks later, when the children were in foster care the mother was felt to be obstructive and placed the children under emotional duress. This was an important omission as the opportunity to complete physical examinations of neglect of Ha, Hb and Hc was significantly delayed by which time important bruises on Hb were faded and evidentially inadmissible. Similarly, the children were underweight and the opportunity to take blood samples for evidence of severe malnourishment and long term neglect were also evidentially compromised as the children had been in foster care for a substantial period of time.

**Learning events comments:**

10.15 There was widespread agreement that information sharing is a difficult issue which is consistently identified in SCRs and must be improved. In this case information sharing practice and professional challenge had not improved across each of the three time periods. The views expressed as far as improving information sharing and professional challenge included:

- the responsibility lies with each agency to share information and not assume it is already known;
- in cases where child neglect is suspected, instances of repeated failures of the child not being brought to developmental health checks, including dental and orthoptic appointments should be monitored more effectively;
- the need for information sharing where there is reasonable concern about significant risk of harm to children always overrides data protection anxieties;
- although currently there are more robust ante-natal pathway and pre-birth risk assessment procedures, this case proves that children can still be born with no or late notification of pregnancies and without the benefit of ante-natal risk assessment or support;
• although MASH decisions involve core team researchers, challenge of decisions is not always occurring, especially where researchers are virtual partners or not available within the MASH team room;
• consultations between concerned agencies and MASH need to be recorded by the agencies and MASH and where the MASH response is considered unsafe or inappropriate, agencies should always challenge this robustly and use the escalation and resolution pathway;
• the escalation and resolution pathway is in place, but it’s use is not being monitored;
• instead of repeatedly using the MASH for consultation where duplicate or increasing concerns border child protection referral levels, consider using professional network meetings;
• ensure that either the designated child protection nurse or a paediatrician are contacted before child protection strategy meetings take place and where appropriate invited to attend; and
• practitioners in all agencies need to be clear about the differences between child protection, FME and LAC medical assessments, currently there appears to be confusion.

11.0 RECOMMENDATIONS:

1. Ensure that, in depth multi-agency training is provided by the SCPB on the emotional abuse and neglect of children and working with them and their families. It is recommended this training is mandatory.

2. Ensure as a priority that multi-agency training on Working Together 2015 is provided by the SCPB takes place to reinforce understanding of roles and responsibilities.

3. Ensure that regular discussion takes place between CSW, and the Law Officers Department on issues and learning arising from recent care proceedings, and to give consideration to the ensuring the Court is kept informed of relevant changes within CSW.

4. Ensure that SCPB multi-agency training is made available to develop communication and assessment skills with children, especially those children with special needs and their siblings who may be subject of emotional abuse and neglect, to ensure that their voices are heard and that they are protected.

5. Ensure the development of an agreed SCPB interagency practice standard for contributions to multiagency assessments, based on a shared language of risk and child development, and, that clear guidance and prompts are put into assessment formats, to assist all agencies’ input to core and parenting assessments.
6. Ensure in cases where targeted centre based parenting courses or other early help interventions have not been meaningfully engaged with by families or fail to have a positive impact, that a formal review with the parents and representatives of relevant agencies must be triggered to consider a step-up approach to CSW engagement and other more appropriate interventions.

7. Urgently implement the resources required and outlined in the recent review of the need for tier 2 and 3 family support workers working in the home.

8. Guidance about the use of consultations with the MASH should be reissued. It is important that an accurate record of the content and outcome of consultations is recorded by both the MASH and the agency concerned. In the event that any agency considers the response to its concerns by the MASH to be unsafe or inappropriate it should always challenge and if necessary use the resolution pathway.

9. Ensure that the MASH strategic group considers the concerns raised by this review and takes all actions necessary to consistently maintain good communication and appropriate challenge within the MASH to enable secure decision making.

10. Where any agency fails to engage with or provide appropriate levels of oversight or support to children considered to be at risk or having high levels of need, it is obligatory for staff in partner agencies service to challenge that practice. All partner agencies should issue standard guidance to staff around challenge and escalation processes in these circumstances. It is mandatory to keep accurate records of the challenge and action taken which are auditable internally and available to the SPB (Children).

11. Consider a SCPB review of current practice to examine how in cases where child neglect is suspected how instances of repeat failure to attend developmental health checks and dental and orthoptic appointments can be monitored more effectively.

12. Ensure a review of the frequency of involvement of a paediatrician or the designated child protection nurse in all child protection strategy meetings over the past six months.
12.0 Appendix 1 Methodology

12.1. Serious Case Review

12.2 A ‘serious case’ is one where abuse or neglect of a child is known or suspected, or where a child has died or has been seriously harmed, and there is concern about the way in which organisations and their staff have worked together to safeguard the child. A Serious Case Review (SCR) is intended to consider whether there are any lessons which may be learned about how organisations in Jersey work together to keep children and young people safe, they are not about culpability but about learning.

12.3 At its meeting on the 30 June 2016, Glenys Johnston OBE, the Independent Chair of the Safeguarding Children Board (SCPB) approved, with the agreement of the Serious Case Review Subgroup that the threshold was met to commission a SCR with regard to the children of a family known for the purposes of this report as the ‘H children’.

12.4 It is the intention that SCRs are published either in full or in part. However, the Independent Chair of the SCPB, with Board members, gives careful consideration when making decisions about publication to balance the benefits of publishing all or some of the review report with the need to protect the rights, including the privacy rights, of individuals. Having considered these issues, the Independent Chair has decided that this Executive Summary should be published.

The Independent Report Author

12.5 The author is an experienced social work professional who qualified as a social worker in 1976 and holds a BA Hons Social Science degree and a MBA. He has worked for several Local Authority Children’s Services and has extensive experience as a social worker, front line and middle manager and has held two senior management positions. In 2004 he joined the Social Services Inspectorate [SSI] as a Local Authority Service Inspector and led a number of SSI children’s safeguarding inspections. In 2007 he was appointed as a HMI for Ofsted and became an Assistant Divisional Manager. Prior to retiring from Ofsted in 2012 he held a national operational lead role within Ofsted for Safeguarding and Looked After Children Inspections and was heavily involved in the coordination and quality assurance of these inspections. Since retiring, he worked for Ofsted as a freelance Associate Inspector as well as working as an independent consultant. He has been involved in an extensive number of pre-inspection and management audits for Local Authorities particularly in relation to child protection.

The Independent Chair

12.6 The SCR was chaired by Nick Watkins, Deputy Governor, HM Prison La Moye, Mr. Watkins is a member of the SPB and brought local knowledge about Jersey practice and culture to the review, he had had no previous involvement with the case.
12.7 Both the independent author and the independent chair are completely independent of all the agencies within this SCR.

12.8. METHODOLOGY

12.9 The policy context

The context for this SCR is found in the Memorandum of Understanding (Co-operation with the Safeguarding Boards for the purpose of safeguarding children and adults in Jersey) (MoU) agreed between the Independent Joint Chair of the Safeguarding Boards and the Ministers, Departments, professionals and organisations with safeguarding responsibilities in Jersey. The MoU provides that any SCR in Jersey should be conducted in accordance with the English and Welsh Government’s Guidance contained in Working Together to Safeguard Children 2015 (*Working Together*). Chapter 4 of the MoU provides that consideration will be given to publishing either in full or in part the overview report of SCRs and the Safeguarding Partnership Board’s (SPB) response to the review findings, having regard to the benefits of publishing and the need to protect the rights of individuals.

12.10 Terms of Reference

Some specific principles which reflect the guidance in *Working Together* were identified for this SCR by the Jersey SCPB as follows:

- The Serious Case Review should be conducted and reported in the context of a culture of learning and improvement across all agencies
- Serious Case Reviews should be proportionate in relation to the scale and level of complexity of the issues being reviewed
- Serious Case Reviews should be led by people who are independent of the case and the organisations involved
- Professionals should be fully involved in the Review
- Families and friends and where appropriate, the child or young person who is the subject of the Serious Case Review should be invited to contribute to the Review and receive feedback on the findings and given an opportunity to comment.

12.11 Chronologies

All agencies involved in working with the H children and their family were required to produce a chronology of their involvement. The period agreed for the chronology and review was from January 2005 to September 2015.

12.12 Manager and Practitioner Events

Senior managers and practitioners from all the agencies were invited to an event to
discuss the issues that had been identified and reflect on their practice. The SCPB is grateful to them for their contributions.

**Family Contributions**

The mother of the children and her partner were invited to contribute to the SCR. The views and opinions expressed by them are appreciated by the SCPB as they have made a significant contribution to the learning from this review. A commitment was made to share the content of the final report with the parents, before the report was presented to the SCPB and a decision on publication was made.

**12.13 Contributions to the Review**

The professionals who contributed to the review included representatives from the following agencies:

- Andium Homes – Housing Service
- Education Services - Teachers
- Education Services - Parenting Support Services, Education Welfare, Wellbeing Team
- Family Nursing and Home Care - health visitors and school nurses
- Health and Social Services - Children’s Services
- Health and Social Services - Children’s Services - Children’s Social Work
- Health and Social Services - Health Care Services - Emergency Department
- Health and Social Services - Health Care Services – Hospital Services, Nursing, (including midwifery)
- Health and Social Services - Health Care Services – Pediatrics
- GP services
- Jersey Family Court Advisory Service
- States of Jersey Police

The Review Panel was assisted throughout by the Jersey SCPB Team to whom they are very grateful.

**12.14 Anonymity**

The objective of this SCR is to identify learning for organisations and professionals whilst minimising the opportunity for the children, their family and others to be identified. For this reason, all names have been changed and in some cases facts have been slightly changed to increase anonymity without affecting the meaning. It is not necessary that identifying details are reported and therefore some information is presented in general or non-specific terms.
13. Appendix 1

REFERENCES

1. Brandon et al 2014 \(^1\) “Missed Opportunities: indicators of neglect-what is ignored, why and what can be done?” DfE Research report November 2014

2. Working Together 2015\(^2\) “Working Together to Safeguard Children - A guide to interagency working to safeguard and promote the welfare of children” HM government March 2015

3. Munro E, 1999\(^3\) “Common errors in reasoning in child protection work” Child Abuse and Neglect, Vol23, No8


6. Brandon 2008\(^7\) “Analyzing child deaths and serious injury through abuse and neglect: what can we learn? DCSF Research Publication

## 14.0 Action Plan

### Action Plan

**Safeguarding Partnership Board – ACTION PLAN**

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<th>Recommendation</th>
<th>How practice is expected to change</th>
<th>Expected outcome for child/ren</th>
<th>Work already undertaken to address this action/narrative</th>
<th>Actions still to be carried out</th>
<th>Title of responsible person</th>
<th>Time frame for completion</th>
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<td><strong>1. Ensure that, in depth multi-agency training is provided by the SCPB on the emotional abuse and neglect of children and working with them and their families. It is recommended this training is mandatory.</strong></td>
<td>Increased understanding and awareness of neglect and emotional abuse</td>
<td>Children and young people are more effectively supported and safeguarded</td>
<td>Commissioned Research In Practice to deliver tailored day of training – November 2017</td>
<td>Provision of mandatory in-depth training</td>
<td>SPB interagency trainers and Practice Development Officer</td>
<td>QTR 4 2017</td>
<td>Training provided, attendance and evaluation monitored through Multi Agency improvement Plan and Training Sub Group</td>
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<td><strong>2. Ensure as a priority that all agencies and services are</strong></td>
<td>All agencies and services are</td>
<td>Children and young people</td>
<td>Working Together to Safeguard and Promote</td>
<td>Multi agency training to be</td>
<td>SPB interagency</td>
<td>QTR 3 2017</td>
<td>Training provided,</td>
</tr>
</tbody>
</table>
multi agency training on Working Together 2015 is provided by the SCPB to reinforce understanding of roles and responsibilities are more effectively safeguarded.

the Welfare of Children and Young People 2015 is followed through the Memorandum of Understanding 2016.

y trainers and Practice Improvem ent Officer.

Developed and provided.

attended and evaluation monitored through Multi Agency Improvement Plan and Training Sub Group.

3. Ensure that regular discussion takes place between CSW, and the Law Officers Department on issues and learning arising from recent care proceedings, and to give consideration to the ensuring the Court is kept informed of relevant:

<p>| All ChS staff will be aware of the court protocol, and understand the threshold for intervention. All staff will be trained in court skills and able to present cases and challenge where appropriate. | Children and young people will be more effectively safeguarded as practitioners work to the court protocol and develop court skills. Legal department approached to facilitate some training for the ChS workforce. | Discussions to take place between CSW and legal department on issues arising from care proceedings., Legal department to co facilitate some court skills and understanding protocol training. | Head of service CHS | QTR 2 2017 | SPB to be advised of outcome and progress. |</p>
<table>
<thead>
<tr>
<th>Changes within CSW.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Ensure that SCPB multi agency training is made available to develop communication and assessment skills with children, especially those children with special needs and their siblings who may be subject of emotional abuse and neglect, to ensure that their voices are heard and that they are protected.</td>
</tr>
<tr>
<td>All that work with children and young people will develop skills in communicating with and assessing children and young people including those children and special needs who may be subject to emotional abuse and neglect. This is critical to ensure children’s voice are heard</td>
</tr>
<tr>
<td>Better assessment of children and young people including the voice of the child will ensure children and young people are more effectively safeguarded</td>
</tr>
<tr>
<td>Multi agency training to be developed and provided</td>
</tr>
<tr>
<td>SPB interagency trainers and Practice Improvement Officer</td>
</tr>
<tr>
<td>QTR 3 2017</td>
</tr>
<tr>
<td>Training provided, attendance and evaluation monitored through Multi Agency Improvement Plan and Training Sub Group</td>
</tr>
</tbody>
</table>
5. Ensure the development of an agreed interagency SCPB practice standard for contributions to multi agency assessments, based on a shared language of risk and child development, and, that clear guidance and prompts are put into assessment formats to assist all agencies input to core and parenting assessments.

This will ensure a holistic view of the child and family in terms of strengths, needs and risks. This can be usefully included in the multi-agency Working Together 2015 multi agency training.

Children and young people will be more effectively supported and protected through multi agency assessment.

Multi agency contributions to Social work assessments required as part of multi-agency procedures.

Inter-agency practice standards, guidance and prompts to form part of the SPB multi agency procedures.

PPA SG and SPB Practice Improvement Officer

QTR 4 2017

Practice Standards, Guidance and Prompts approved by SPB and embedded in MA procedures.
6. Ensure in cases where targeted centre based parenting courses or other early help interventions have not been meaningfully engaged with by families, or, fail to have impact, that a formal review with the parents and representatives of relevant agencies must be carried out. Children and young people are more effectively supported and protected through checking to see interventions have the intended impact. This is in place for those children and young people have a team around the child and family.

<table>
<thead>
<tr>
<th>Consider extending the early help approach guidance to include or develop as separate practice guidance?</th>
<th>Early Help Project Sub Group</th>
<th>QTR 3 2017</th>
<th>Practice guidance developed and embedded in training</th>
</tr>
</thead>
</table>

All who work with children and young people to be reminded to check with parents and children the impact of early help support and parenting courses where these have been recommended. Consideration to be given as to meaningful engagement and attendance. If this has not happened then a review with the parents and the provider of the service and relevant agencies must be carried out.
be triggered to consider a step up approach to CSW engagement and other more appropriate interventions.

<table>
<thead>
<tr>
<th>7. Urgently implement the resources required and outlined in the recent review of the need for tier 2 and 3 family support workers working in the home.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This serious case review highlighted the importance of home based family support being available and accessible at both an early intervention and statutory service level</td>
</tr>
<tr>
<td>Families do not have to wait until problems become so bad or entrenched they need a statutory service to access family support in the home</td>
</tr>
<tr>
<td>Already in place in the Children’s Service</td>
</tr>
<tr>
<td>Early intervention Family Support agreed as Category 2 in the IJCI response.</td>
</tr>
<tr>
<td>Funding to be confirmed</td>
</tr>
<tr>
<td>QTR 2 2017</td>
</tr>
<tr>
<td>Director Inclusion and Family Support – Education Department</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Guidance about the use</th>
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</thead>
<tbody>
<tr>
<td>Practitioner are clear about the Children and young people</td>
</tr>
<tr>
<td>Guidance in development</td>
</tr>
<tr>
<td>Advice of LoD needed to ensure</td>
</tr>
<tr>
<td>QTR 2 2017</td>
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<tr>
<td>HoS Safeg</td>
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<tr>
<td>Guidance issued and</td>
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36
of consultations with the MASH should be reissued. It is important that an accurate record of the content and outcome of consultations is recorded by both the MASH and the agency concerned. In the event that any agency considers the response to its concerns by the MASH to be unsafe or inappropriate it should always challenge and if necessary use the resolution pathway.

| Purpose and function of consultations and can access advice appropriately | are more effectively supported and protected | appropriate sharing and retention of information | included in the multi-agency procedures
<table>
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<tbody>
<tr>
<td>Guidance to be issued after sign off by SPB</td>
<td></td>
<td></td>
<td>SPB Board Manager</td>
</tr>
</tbody>
</table>
9. **Ensure that the MASH strategic group considers the concerns raised by this review and takes all actions necessary to consistently maintain good communication and appropriate challenge within the MASH to enable secure decision making.**

<table>
<thead>
<tr>
<th>Action</th>
<th>Context</th>
<th>SCR findings and recommendations to be considered by MASH Strategic Group</th>
<th>HOS safeguarding</th>
<th>Timeframe</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good communication and effective challenge are promoted as a foundation of effective child protection practice in a multi-agency system</td>
<td>MASH strategic group members part of SCPB and have sight of this SCR</td>
<td></td>
<td></td>
<td>QTR 2 2017</td>
<td>SPB able to ensure this through report of any actions needed and progress against actions if required</td>
</tr>
</tbody>
</table>

| 10. **Where any agency fails to engage with or provide appropriate levels of oversight or support to** | Colleagues in partner agencies are clear about responsibilities to challenge practice where there is concern | FNHC already have a system in place where escalation/challenge is recorded and can be reported on | To be considered at Policy, Procedures and Audit Sub Group. May require review of the Escalation and Resolution Pathway | PPA SG All agencies | QTR 4 2017 | Regular reports available for SCPB |

| | Children and young people are more effectively safeguarded and their welfare protected | | | | | |
| children considered to be at risk or having high levels of need, it is obligatory for staff in partner agencies service to challenge that practice. All partner agencies should issue standard guidance to staff around challenge and escalation processes in these circumstances. It is mandatory to keep accurate records of the challenge and action taken which are auditable | that children are at risk or have high levels of need |   |   |
11. Consider a SCPB review of current practice to examine how in cases where child neglect is suspected how instances of repeat failure to attend developmental health checks and dental and orthoptic appointments can be monitored more effectively.

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<tbody>
<tr>
<td>Internally and available to the SPB (Children).</td>
<td>Issue practice guidance to health professionals in clinics/GP surgeries to identify children who do not attend as not brought. The guidance to include factors to consider in terms of whether appointment for review, check, diagnostic and implications for the child of not being brought. This should include guidance as to when to alert</td>
<td>Children will be more effectively protected and supported</td>
</tr>
<tr>
<td></td>
<td>Hospital clinics operate a 3 DNA alert to Designated Safeguarding Nurse</td>
<td>Task and Finish Group with representatives of health providers. FNHC Hospital Dentists GPs Community health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FNHC Chief Executive/Chief Nurse/Designated Dr/Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>QTR 3 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practice guidance in place – agreed by SCPB</td>
</tr>
<tr>
<td>12. Ensure a review of the frequency of involvement of a paediatrician or the designated child protection nurse in all child protection strategy meetings over the past six months.</td>
<td>Ensures consideration of medical needs and any required medical at an early and appropriate stage</td>
<td>Children and young people are more effectively supported and protected</td>
</tr>
</tbody>
</table>
### Education Department

<table>
<thead>
<tr>
<th>Action</th>
<th>How practice is expected to change</th>
<th>Expected outcome for children or adults</th>
<th>Work already undertaken to address this action/narrative</th>
<th>Actions still to be carried out</th>
<th>Title of responsible person</th>
<th>Timeframe for completion</th>
<th>Evidence and date of completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All sections of the Education Department to ensure concerns and actions are recorded accurately and efficiently and stored chronologically</td>
<td>Patterns of concern are observed and acted upon in a timely manner</td>
<td>Safe decision making based on accurate information</td>
<td>The DSO has worked with a group of headteachers to develop paperwork for accurate record keeping</td>
<td>Ratification by SMT and disseminated to Heads</td>
<td>Designated Safeguarding Officer</td>
<td>QTR 1 2017</td>
<td></td>
</tr>
<tr>
<td>2. The Designated Safeguarding Officer should ensure that all Designated lead teachers and lead staff in other educational establishment must share</td>
<td>Decision making in educational establishments will be safer</td>
<td>Children and young people better safeguarded</td>
<td>The DSO has instructed all designated leads to ensure that all staff are reminded of existing policy and process</td>
<td>None</td>
<td>DSO</td>
<td>QTR 1 2017</td>
<td></td>
</tr>
</tbody>
</table>
and discuss concerns regarding safeguarding with other involved agencies.

| 3. The Director for Inclusion and Family Support will ensure that the formal induction process for new Head teachers includes a section on safeguarding and welfare concerns with the outgoing Head teacher and Designated Lead Teacher which requires signing off | Head teachers who are accountable for safeguarding in their schools will be aware of concerns and more able to monitor and ensure procedures are adhered to | Children are safer as Headteachers have full information | The Learning and Development Manager to include this action in the Headteacher Induction document which is signed off. | LDM and Director for I&FS to establish process | Director | QTR 1 2017 |
| when complete | 4. The Director for Inclusion and Family Support will ensure that a) all staff are informed that a service exists that provides confidential support 24/7 for them b) all schools have in-house counselling and supervision structure for staff | Well-being of staff will improve | Staff are aware of how to access support | a. The 24hr ‘Be Supported’ confidential support service is in place | a. The HR Department will re-send all headteachers the information regarding this service and further raise awareness b. Education Safeguarding Board to establish process for in-house counselling. Headteachers will state structure/process for in-house provision. PPs will ensure that provision is in place | Director | January 2017 |
## Family Nursing and Home Care

<table>
<thead>
<tr>
<th>Action</th>
<th>How practice is expected to change</th>
<th>Expected outcome for the child</th>
<th>Work already undertaken to address this action/narrative</th>
<th>Actions still to be carried out</th>
<th>Title of responsible person</th>
<th>Time frame for completion</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All staff to attend multi-agency training on emotional abuse/ neglect/ working together</strong></td>
<td>Staff will be able to demonstrate practice based on theory.</td>
<td>Improved response from HV/SN staff</td>
<td>Staff released and encouraged to attend training</td>
<td>SPB training prospectus for 2017 to be circulated to all staff</td>
<td>Operational Lead for Children FNHC/ SCPB trainers</td>
<td>QTR 4 2017</td>
<td>% of staff who have attended multi-agency training</td>
</tr>
<tr>
<td><strong>HV/SN to directly contribute to the core &amp; parenting assessment when</strong></td>
<td>a health assessment written by the HV/SN will be available to the SW / courts</td>
<td>Health information will be accurate and inform practice</td>
<td>Op lead to discuss with Safe guarding manager to agree the process</td>
<td>Meeting to be arranged</td>
<td>Operational lead FNHC/ Head of Service Safeguarding</td>
<td>QTR 2 2017</td>
<td>HV/SN requests for health assessment Completed</td>
</tr>
<tr>
<td>requested to do so by the SW.</td>
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<tr>
<td><strong>Review the policy for the DNA of child health assessments</strong></td>
<td>Aim to prioritise HA for children who are universal plus / partnership. Consider MASH referral for persistent DNA</td>
<td>Developmental delays will be identified and the appropriate referrals/treatment actioned</td>
<td>Review SOP</td>
<td>Policy to be reviewed, amended and circulated</td>
<td>Operati onal Lead for Children FNHC</td>
<td>QTR 2 2017</td>
<td>90% of targeted reviews completed.</td>
</tr>
</tbody>
</table>

### States of Jersey Police

<table>
<thead>
<tr>
<th>Action</th>
<th>How practice is expected to change</th>
<th>Expected outcome for child</th>
<th>Work already undertaken to address this action/narrative</th>
<th>Actions still to be carried out</th>
<th>Title of responsible person</th>
<th>Time frame for completion</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The need for a medical examination is always considered and advice is sought from appropriate health staff</strong></td>
<td>Medical examinations are routinely considered in child protection cases and pay attention to the child’s wider welfare and</td>
<td>Promote healthy development and positive wellbeing</td>
<td>Detective Sergeants in PPU have been briefed on the learning from this SCR and know to raise the issue of a medical examination in strategy meetings and</td>
<td></td>
<td>Detective Inspector</td>
<td>Complete</td>
<td>Strategy Meeting Minutes.</td>
</tr>
</tbody>
</table>
**when making decisions about the need for a medical examination.**

| health needs as well as forensic evidence. | challenge where appropriate. |  |  |  |  |  |  |

ENDS